Nebraska Residual Malpractice Insurance Authority
Professional Liability Application
Occurrence Form

PART A – APPLICANT INFORMATION

1. Last Name	First Name	M.I.
2. DOB _____/_____/_____	3. SSN _____ - _____ - _____	4. Gender ☐ M ☐ F
5. Home Address		
City	State	Zip
6. Primary Practice Address		
City	State	Zip
Office Phone #	Office Fax #	
Additional Contact #	e-mail address	

7. Current Form of Insurance ☐ Occurrence ☐ Claims- Made	Retroactive Date (if applicable)	Current Carrier
Limits of Coverage	Dates of Coverage ____/____/____ to ____/____/____	Currently Participating in the Act ☐ Yes ☐ No

PART B – COVERAGE REQUESTED

8. Requested Effective Date _____/_____/_____	
9. Are you requesting coverage for your Professional Corporation or Employees? ☐ Yes ☐ No If "yes" please indicate which one and/or both. ☐ Professional Corp. ☐ Employee(s)	
10. Type of practice ☐ Physician ☐ Intern/Resident ☐ Certified Registered Nurse Anesthetists	Member of: ☐ Professional Corp. ☐ Partnership ☐ Limited Liability Corp. ☐ Other_____

11. If you are practicing as a solo entity, as a member of a multi-shareholder entity such as a partnership, limited liability corporation, professional corporation, limited liability partnership or professional association or are in another type of group practice such as an implied partnership or corporation, please provide the exact legal names of all medical entities to be insured. **Please remember to attach to the application a copy of each entity's current declarations page.** Please use the Notes Section if additional space is needed.

Entity Names:	Involvement/Ownership:
_____	☐ Limited Partner ☐ General Partner ☐ Solo Ownership ☐DBA
_____	☐ Limited Partner ☐ General Partner ☐ Solo Ownership ☐DBA
_____	☐ Limited Partner ☐ General Partner ☐ Solo Ownership ☐DBA

12. Please give the full names of all other physicians affiliated with any organization(s) or medical entities named in question 11, their specialties and the name of their current medical professional liability insurer. **All affiliated physicians must complete a separate application if organization or entity coverage is requested.** Please use the Notes Section if additional space is needed.

Name:	Specialty:	Current Insurance:

13. Employer Name_____

14. Name of any other entity with which you are associated or affiliated _____

15. Please list **all** employees names, professional occupations, their license numbers and the name of their current medical professional liability insurer, of those that are to be included as **additional insureds** (i.e. PA, RN, LPN, etc.). Please use the Notes Section if additional space is needed.

Name:	Occupation:	License Number:	Current Insurance:

PART C – LICENSE INFORMATION

16. List **all** states in which you have ever been or are currently licensed to practice medicine, the license number for that state, the date the license was issued and the percentage of your current practice in that state. (Please use the Notes Section if additional space is needed.)				
State	License Number	Date Issued	Number of hours per week	Status of License
				☐ Active ☐ Inactive
				☐ Active ☐ Inactive
				☐ Active ☐ Inactive
				☐ Active ☐ Inactive

PART D – PROFESSIONAL LIABILITY INSURANCE HISTORY

17. Please list your previous insurance coverage			
Name of Company (Current)	Policy Limits $_____/$_____	Period of Coverage: ___/___/___ to ___/___/___ Retroactive Date: _____/_____/_____	☐ Claims-Made ☐ Occurrence
Name of Company (Previous)	Policy Limits $_____/$_____	Period of Coverage: ___/___/___ to ___/___/___ Retroactive Date: _____/_____/_____	☐ Claims-Made ☐ Occurrence
Name of Company (Previous)	Policy Limits $_____/$_____	Period of Coverage: ___/___/___ to ___/___/___ Retroactive Date: _____/_____/_____	☐ Claims-Made ☐ Occurrence

If your current insurance is claims-made, will "tail coverage" be purchased**?……☐ Yes ☐ No

**This coverage is provided on an occurrence form only, prior acts coverage is not available. Therefore, in order to have coverage for you previous acts you must purchase tail coverage from your current insurer as well as the Nebraska Excess Liability Fund.

PART E – EDUCATION

18. Please list your education history.			
Name of Medical/Osteopathic School	Degree	Location	(Mo./Yr.) From (Mo./Yr.) To

If you are a foreign medical school graduate, are you certified by the Educational Commission for Foreign Medical Graduates (ECFMG?)……. ☐ Yes ☐ No

19. Please list any and all Internship(s), Residency(ies) and Fellowship.					
	Program Name	Department	Location	(Mo./Yr) From (Mo./Yr.) To	Program Completed
Internship Served					☐ Yes ☐ No*
Residency(ies)					☐ Yes ☐ No*
					☐ Yes ☐ No*
					☐ Yes ☐ No*
Fellowship(s)					☐ Yes ☐ No*
					☐ Yes ☐ No*

*** If "No" is indicated, explain fully in the Notes Section.**
Please explain any gaps in your medical education in the Notes Section. "Gaps" are defined as periods of time of 90 days or more in which you were not actively enrolled in an internship, residency, fellowship or preceptorship program.

PART F – PRACTICE HISTORY

20. List your professional practice history for the past 5 years.		
Location	Type of Practice/Position	(Mo./Yr.) From (Mo./Yr.) To

Please explain any gaps in your practice history in the Notes Section. "Gaps" are defined as periods of time of 90 days or more in which you were not actively practicing medicine.

21. What is your Specialty?

22. What is your Subspecialty?

23. Has your Specialty or Subspecialty changed in the last 5 years? ☐ Yes* ☐ No
*If yes, please describe the nature of changes in specialty, classification or practice activities in the Notes Section.

24. Percentage of your practice devoted to your Specialty _____

25. Percentage of your practice devoted to your Subspecialty _____

26. What professional organizations are you a member of?
☐ AMA ☐ State Medical ☐ Other _____
☐ AOA ☐ County Medical

27. Are you certified by an approved specialty board?

☐ Yes ☐ No Name _____

Date of initial certification _____ Date(s) of recertification _____

28. Have you ever been denied board certification or recertification? ☐ Yes* ☐ No

If "yes" please explain in the Notes Section.

PART G – PRACTICE CHARACTERISTICS

29. List all hospitals as which you have or will have staff privileges in force for which you are requesting this coverage and indicate the type of privileges you hold at each:

Name of Hospital	Type of Privilege
_____	Active ☐ Provisional ☐ Courtesy ☐ Pending ☐ Other ☐
_____	Active ☐ Provisional ☐ Courtesy ☐ Pending ☐ Other ☐
_____	Active ☐ Provisional ☐ Courtesy ☐ Pending ☐ Other ☐
_____	Active ☐ Provisional ☐ Courtesy ☐ Pending ☐ Other ☐
_____	Active ☐ Provisional ☐ Courtesy ☐ Pending ☐ Other ☐

Please explain any "pending" or "other" answer here. If you explain a "pending" answer, please provide the date you initially applied for these privileges. _____

_____

If additional space is needed, please use the Notes Section.

30. If you made no entry in #30 above, please provide details regarding your patients who require hospital care including the names and practice locations of all physicians who will follow them while hospitalized.

_____

_____

_____

31. After the Requested Effective Date, do you plan to practice/consult outside Nebraska in the next 12 months? ☐ Yes ☐ No

If "yes" you will need to maintain other professional liability insurance this exposure, as the Nebraska Residual Fund will only provide coverage for your Nebraska exposure.

32. Do you participate in telemedicine? ☐ Yes* ☐ No

(For purpose of this question, telemedicine is defined as "the rendering of a written or otherwise documented medical opinion concerning diagnosis or treatment of an individual patient as a result of transmission of individual patient data by electronic …… means." Telemedicine does not include an informal consultation provided without compensation or expectation of compensation, nor does it include those services described above which are rendered in a bona fide emergency.)

If "yes" please explain in the Notes Section.

33. If you are a radiologist or pathologist, do you or will you read, interpret or diagnose films, slides or specimens taken of patients who reside outside the state of Nebraska? ☐ Yes ☐ No

If "yes", please indicate the state(s) or foreign country(ies) in which the patients being treated reside:

_____

And the number of hours per week you will devote in each state or foreign country: _____

_____

34. Do you assist at surgery? ☐ Yes ☐ No

35. In your practice, do you perform procedures or use equipment not used by a majority of physicians in your specialty who practice in Nebraska? ☐ Yes ☐ No

If "yes" please explain _____

_____

_____

36. Do you perform any procedures that are non-FDA approved? ☐ Yes ☐ No

If "yes", please list all procedures. _____

_____

37. Do you perform any of the following procedures?

Autologous fat injections into breasts or penises	☐ Yes ☐ No
Chelation therapy (other tan for treatment of heavy metal poisoning)	☐ Yes ☐ No
Cymopapain disc injections	☐ Yes ☐ No
Elective home delivery	☐ Yes ☐ No
Intravascular absolute alcohol embolization	☐ Yes ☐ No
Jejuno-ileal bypass or gastric bubble procedures for treatment of morbid obesity	☐ Yes ☐ No
Prolotherapy	☐ Yes ☐ No
Rapid opiate detoxification	☐ Yes ☐ No
Sclerotherapy (the injection of sclerosing agents) into the vertebral column	☐ Yes ☐ No
Sperm bands for other than interim storage for insemination of your own patients	☐ Yes ☐ No
Transsexual surgery	☐ Yes ☐ No
Use of chorionic gonadotropin in the treatment of obesity	☐ Yes ☐ No
Use of Laetrile (Amygdalin or vitamin B-17)	☐ Yes ☐ No

38. Do you provide surgical services to patients in any setting in which another person provides the post-op follow-up care for that procedure? ☐ Yes ☐ No

39. Do you supervise CRNAs who provide general anesthesia? ☐ Yes ☐ No

40. Do you perform obstetrical procedures? ☐ Yes ☐ No

If "yes", please indicate the average number of deliveries performed per year _____ and the average number of C-sections performed per year _____.

41. If you are a Family Practitioner performing obstetrics, do you have privileges to perform C-sections at each hospital you staff? ☐ Yes ☐ No

If "no" please provide full details of your back-up arrangements including coverage for VBAC patients.

42. Other than to maintain hospital privileges, do you practice in an Emergency Department? ☐ Yes ☐ No

If "yes", please indicate number of hours per week. _____

43. Do you or will you perform conscious sedation? ☐ Yes ☐ No

If "yes", do you or will you?

a. utilize reversal agents at bedside? ☐ Yes ☐ No

b. maintain the ability to breathe for the patient? ☐ Yes ☐ No

c. ensure that continuous and constant patient monitoring is done by a qualified person from the initiation of sedation until the patient is cleared for discharge? ☐ Yes ☐ No

For purpose of this question, "monitoring" is defined as observing and recording a patient's pulse oximetry, vital signs and depth of sedation.

44. Do you perform "invasive" procedures? ☐ Yes ☐ No

"Invasive" refers to procedures by which the body or body cavity is penetrated or entered by use of a tube, needle, device or ionizing radiation. If "yes" list all such procedures:

Procedure	Resident-Trained?	Hospital-Privileges?
	☐ Yes ☐ No	☐ Yes ☐ No
	☐ Yes ☐ No	☐ Yes ☐ No
	☐ Yes ☐ No	☐ Yes ☐ No
	☐ Yes ☐ No	☐ Yes ☐ No
	☐ Yes ☐ No	☐ Yes ☐ No
	☐ Yes ☐ No	☐ Yes ☐ No
	☐ Yes ☐ No	☐ Yes ☐ No
	☐ Yes ☐ No	☐ Yes ☐ No

45. Do you perform:

Prenatal care beyond the first trimester? ☐ Yes ☐ No
Second-trimester abortions? ☐ Yes ☐ No
C-Sections? ☐ Yes ☐ No
Angiography? ☐ Yes ☐ No
Breast biopsy by surgical incision? ☐ Yes ☐ No
Cardiac catheterization? ☐ Yes ☐ No
Liposuction surgery using the tumescent technique? ☐ Yes ☐ No
Liposuction surgery using any technique other than tumescent? ☐ Yes ☐ No
Reduction of open fractures? ☐ Yes ☐ No
Reduction of undisplaced closed fractures? ☐ Yes ☐ No
Reduction of displaced closed fractures? ☐ Yes ☐ No

46. In your practice, do you utilize FDA experimental drugs other than through Institutional Review Board (IRB) approved research programs? ☐ Yes ☐ No

If "yes", will the study indemnify your? ☐ Yes ☐ No

47. Do you use a physician/patient arbitration agreement in your practice? ☐ Yes ☐ No

For this purposes of this question, "physician/patient arbitration agreement" refers to a document you ask patients to sign prior to providing healthcare services which stipulates that any dispute between you and the patient will be submitted to arbitration as opposed to resolution in the state or federal courts.

PART I – OTHER INFORMATION

All "yes" answers require explanation in the Notes Section

48. Has any professional liability insurer ever canceled, declined to issue, refused to renew, or issued coverage with any restrictions or exclusions? ☐ Yes ☐ No
49. Has any disciplinary action ever been taken against any healing arts license that you hold or have ever held? Include any disciplinary actions by the U.S. Military, U.S. Public Health Service or other U.S. federal governmental entity. (Disciplinary actions, include, but are not limited to, suspension, revocation, probation, practice limitation, reprimand, letter of admonition, censure and any allegations which are currently pending) ☐ Yes ☐ No
50. Has your license to practice medicine or your permit to prescribe drugs ever been denied, revoked, suspended, voluntarily, surrendered, or otherwise investigated or limited, in any way? ☐ Yes ☐ No
51. Have you ever been subjected to a criminal or civil monetary penalty under the Medicare or Medicaid program and/or been suspended from participation in Medicare or Medicaid or has participation status ever been modified? ☐ Yes ☐ No
52. Have you ever been charged, indicted, convicted, received a deferred prosecution, received a deferred judgment and sentence, entered a guilty plea, entered a plea of nolo contendere or been placed on adult diversion for any violation of any law? Note: You must answer "yes" even if charge(s) or action was ultimately dismissed, expunged, pardoned or the matter was not prosecuted. It is unnecessary to report traffic offenses that do <u>not</u> include alcohol or drugs. ☐ Yes ☐ No
53. Have you ever been warned, reprimanded, or censured by a medical staff, hospital, health care facility, or any other health care entity? ☐ Yes ☐ No
54. Have you incurred or suffered any chronic illness or physical injury in the past 24 months? ☐ Yes ☐ No
55. Have you ever had staff privileges at a hospital limited, reduced, restricted, denied, suspended or revoked, or have you resigned from a medical staff in lieu of disciplinary action or potential disciplinary action? ☐ Yes ☐ No
56. Have you ever failed any licensing or Board certification examinations? ☐ Yes ☐ No
57. Have you ever had a patient or patient representative complain to or file a grievance of any type with a hospital committee, State Licensing Board, Board of Medical Examiners, health plan, managed care organization, or other medical review committee? ☐ Yes ☐ No
58. Have you ever been evaluated or recommended for treatment for, diagnosed with, or treated for alcohol, narcotics, or any other substance abuse, sexual addiction or mental illness? ☐ Yes ☐ No
59. Have you every been accused of sexual misconduct or harassment by one of your employees, an associate's employee or an employee of a hospital or surgery center, or have you been accused by a patient of or been investigated by any state regulatory authority in connection with boundary violations of a sexual nature? ☐ Yes ☐ No
60. Have you ever been reported to the National Practitioners Data Bank? ☐ Yes ☐ No

PART J – CLAIMS INFORMATION

Important information regarding questions 63 and 64 (including sub-questions):

1. The word "claim" as used in Questions 63 and 64 below refers to:

    a. Any demand for damages, resolved or pending, regardless of the result, arising from your professional activity and brought against you or any partner, associate, employee or professional corporation or partnership; or

    b. Circumstances which have been brought to your attention by a patient or representative of a patient, in such a manner as to indicate the possibility of action against you or any partner, associate, employee or professional corporation or partnership.

2. If you answer "yes" to questions 63 and/or 64 (including sub-questions please complete the attached Supplementary Claims Information Form.

61. Have you ever been involved in a malpractice claim or suit, either directly or in directly? ☐ Yes ☐ No

62. Are you aware of any of the following circumstances that might reasonably lead to a claim or suit being brought against you even if you believe the claim or suit would be without merit? ☐ Yes ☐ No

a. A request for records from a patient and/or attorney related to an adverse outcome? ☐ Yes ☐ No
b. A letter from an attorney regarding you medical treatment of a patient? ☐ Yes ☐ No
c. Intra-operative or post-operative complications or other complication resulting in death, paralysis, or other significant disabilities? ☐ Yes ☐ No
d. Patient or family member dissatisfaction with the outcome of a procedure, treatment or diagnosis? ☐ Yes ☐ No
e. Any other circumstances that might reasonably lead to a claim or suit? ☐ Yes ☐ No
f. Have all circumstances that might reasonably lead to a claim or suit (even if you believe the possible claim or suit would be with out merit) been reported to your current or prior professional liability carrier? ☐ N/A ☐ Yes ☐ No
    i. If "yes" how many? _____ Please attach documentation of all such reports.
    ii. If "no", please explain in Notes Section.

For purpose of this question "N/A" means that you are not aware of any circumstances that might reasonably lead to a claim or suit.

Signing this application does not bind the Authority to provide the insurance. All information requested in this application is considered material and important. If the Authority agrees to be bound under the terms of this application, your policy is void if you hide or withheld any important information, mislead, or attempt to defraud the Authority in any matter contained in this application. Also, your signatures grants authorization to contact your previous carrier to secure further underwriting information, if deemed necessary. It this application is approved by the Nebraska Residual Authority, coverage will not begin until premium payment is received.

Signature of Applicant: _____ **Date:** _____

Name of Applicant (Print) _____

PART K – SUPPLEMENTARY CLAIMS INFORMATION FORM

If there has been more then one claim, please photocopy this form. All questions must be answered or marked Not Applicable (N/A)

1. Patients name _____

2. Date reported to insurance company _____

3. Name of insurance company_____

4. Date of incident and your treatment: _____

5. Allegations: _____

_____

_____

6. What is the present condition of the patient? _____

_____

_____

7. Did you in any way alter, embellish, delete, change and/or destroy any records, medical or otherwise, or were allegations made that you did so, pertaining to this claim? ☐ Yes ☐ No

8. Status of claim (check applicable answer):	9. Payment Information:
☐ Suit threatened, no action taken ☐ Suit filed but dropped by claimant ☐ Awaiting mediation ☐ Awaiting court action ☐ Summary judgment in your favor ☐ Court outcome in your favor ☐ Court outcome in favor of plaintiff ☐ Suite settled out of court	a. Date claim was paid: _____ b. Reserve Amount: $_____ c. Amount paid: $_____ d. Amount of loss payment $ _____ e. Did you want to settle this claim ☐ Yes ☐ No

10. To you knowledge, was any settlement paid by another party involved (i.e., your P.A., P.C., partners, employees, etc.)? ☐ Yes ☐ No

Signature: _____ **Date:** _____

Name (Printed): _____

NOTES SECTION

Question # Comments

If additional space is needed please copy this form

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If additional space is needed please copy this form